An International Classification of Mental Diseases.

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The tendency of the human mind in general, and perhaps of the American mind in particular, is to arrange and systematize many kinds of facts or data in groups, families, or classes, so that they may fall into their proper and definite places, and henceforth be of service as known factors, the full value of which has been ascertained once and for all.

In all branches of science we have seen this tendency, and have furthermore often seen the fulfilment of such a purpose. Agassiz for instance in natural history, has shown what may be done by arranging and classifying the different kinds of fishes beginning with the earliest fossil forms. This was a work of extreme intricacy and delicacy, requiring a master-mind to unravel its secrets. The data to be classified however, when once recognized, were of a fixed, unalterable character never to be changed, if correctly ascertained, to the end of time.

A precisely similar theory was in early times applied to medical diseases. These also were supposed to have a fixedness of type which made them readily fall into a nosological system. Hence arose complicated, elaborate and theoretical nosologies, excellent in their way, provided they represented data of unimpeachable accuracy, otherwise worse than useless for succeeding generations, from their complicated character and theoretical ground-work. The actual knowledge of physical processes was unfortunately in these early times, in inverse ratio to the involved system of nosology.

As these processes have, step by step, become unfolded by careful scientific investigation, we find the total number of proven facts immensely augmented. We are embarrassed by their number and variety, yet we are unable to satisfactorily classify them. They can not be made by any possibility to fit into old nosologies, which are now only of interest from the light they throw on the past history of medicine. Neither can we place them together into a perfect system for present use. If we have learned anything from the discoveries of modern science, it is that medicine is not, as yet, a fixed science; not from the inexact character of physical

phenomena, but from our limited power of interpretation of these phenomena.

In the study of natural laws as applied to man, the splendid progress of the present century is demonstrated by the certainty that we are on the right road to further knowledge, but with this feeling comes one also of skepticism. Whereas a century ago we were satisfied with crude theories, to-day we can accept nothing unless proved by actual demonstration. While we appreciate the need of applying a correct name to each form of disease, and arranging all diseases together in a comprehensive system, there is little possibility that this will be done further than to place certain well-recognized varieties apart by themselves under general headings as appropriate as our present knowledge warrants.

What is true of diseases in general, may be said to be especially true of mental diseases. So far these diseases have defied all efforts at a satisfactory classification, in spite of the intelligent and persistent efforts made by the writers of the present century. Exposed to careful criticism, each system has proved either inaccurate, insufficient, or too complex. No wonder that such has been the case, when we remember how little real knowledge we have had on the subject of cerebral action. The psychological or speculative side of mental manifestations first attracted notice, and from this point of view the most fanciful and impossible of classifications were elaborated. Some of these were of value from the insight they imparted into the recognized moral qualities of the mind, otherwise they could not be put to practical use.

As we look back upon the history of psychological medicine, we can readily see that we could expect nothing more than this. The demonstrative period in medicine had not arrived: theory, speculation, mysticism, were resorted to to explain simple physical processes, even then easily demonstrable. The prevailing ignorance of actual conditions was exaggerated, when directed toward mental operations. The mind was an unknown quantity, shrouded in darkness, and subject to the misinterpretation of ignorance and superstition. It was natural that the moral, emotional, spiritual elements of the mind should receive the most profound study, and hence arose many distorted ideas of mental action, which from the earliest period down to the present day, have embarrassed the consideration of morbid mental action. The idea that insanity was equivalent to demoniacal possession for instance, has steadily influenced its treatment from the first, and though we may now laugh at it, we cannot deny that many

persons still cherish an idea somewhat similar in character. It is a disgrace, these people say, to go to an insane asylum. But why a disgrace, if some immoral, vicious or depraved element does not influence the outbreak of the mental disease? They see in the outbreak, a more or less direct punishment for a moral transgression. They lose sight of the intervening physical processes, which are the direct and true causes of the attack, and call a *physical* a *moral* transgression. I do not mean to deny here, that moral laws, which frequently are natural laws, can be broken without danger to mental integrity. On the contrary, a correct moral process is as necessary to mental health as any correct physical process and every abnormal departure is attended with danger. But what I do wish to combat is the idea, still so prevalent, that insanity is in some measure a sin as well as a disease, and to be looked at somewhat as a spiritual transgression. Perhaps it may be said I state the case too strongly, but no one will deny, I think, that there is still a certain stigma partially moral in character attached to an outbreak of mental disease unlike that associated with any other disease. The subject of the attack is looked at with more or less suspicion, and commiserated for his misfortune, which has lowered him somewhat in the estimation of his fellows. In time even this remnant of the old feeling will disappear, and persons suffering with mental diseases will be as openly treated and talked about among their friends as are the patients in general hospitals.

Haslam in the second edition of his entertaining book called "Observations on Madness," and published nearly eighty years ago, speaks of "Insanity being now generally divided into mania and melancholia (it will be observed he naturally speaks of mania first as we do at the present time), but formerly its distributions were more numerous." He refers to Paracelsus, who differentiates lunatici, insani, vesani and melancholici, making a separate class of each. "Paracelsus, who contemplated this subject (demoniacal possession) with uncommon gravity and solicitude, is of opinion that the devil enters us much in the same manner as a maggot gets into a filbert." These extraordinary ideas of Paracelsus seemed to exert no influence on his classification of the divisions of insanity.

Haslam further refers to Dr. Ferriar, who divided insanity into mania and melancholia. "In mania he conceives false perception, and consequently confusion of ideas to be a leading circumstance." Melancholia "he supposes to consist in intensity of idea, which is

a contrary state to false perception." Haslam differs from Ferriar, partly, it would appear, in the use of words. He does not think that false perception, for instance, is a leading circumstance in mania, for he understands with Locke that perception means "the apprehension of sensations," and he has not frequently found that insane people perceive falsely the objects which have been presented to them.

It is possible that he misunderstood Ferriar's conception of the meaning of perception, which may not have been restricted to the apprehension of sensations, or physical phenomena merely, but may have included the apprehensions of mental impressions of all kinds. In their wider sense we can easily accept this definition as far as this portion of it is concerned. The confusion of ideas in mania, would be true of many forms, but not necessarily of all.

The element of intensity is certainly characteristic of melancholia, and it is a good word to use in defining this form of disease. As Haslam truly says this definition applies also to mania, though hardly equally, as he thinks. On the contrary, the intensity of mania is shown in general mental and muscular activity, and is the reverse of the circumscribed intensity of thought and feeling amounting to absolute pain in the mental process (psychalgia of Clouston), in melancholia.

Without proceeding further in this discussion of terms and definitions, we may accept mania and melancholia as having been pretty firmly established, and on a fairly scientific basis, at least, as early as the beginning of the present century. That these two forms of mental disease have stood the test of time, the severest of all tests, is a proof that they contained elements of truth and practical usefulness, not to mention scientific accuracy.

Burrows* at a later period in the century (1828), speaks of a definition suitable to every form of insanity, as an *ignis fatuus* in medical philosophy which all follow, and which eludes and bewilders pursuit. He mentions the variety in the nomenclature of mental disorders, citing as examples the *Deliria* of Sauvages and Sagar; the *Paranoiae* of Vogel and Swediaur (the first allusion to the term paranoia I am familiar with); *Ideales* of Linnæus; the *Mental Diseases* of Macbride; the *Vesaniae* of Cullen; the *Para neurisinic* of Young; the *Delirium* of Crichton and Foderé; the *Aliénation Mentale* of Pinel; the *Folie* of Esquirol; *Echphronia* of Good, &c.

*Commentaries on the Causes, Forms, Symptoms, Treatment, Moral and Medical, of Insanity. By George Man Burrows, M. D.

Mania and melancholia he objects to, because they do not preserve that permanency of character which is necessary to a genus. He even doubts their pretensions to be considered as distinct species. He mentions the great number of varieties of melancholia made by nosologists, and cites old Burton, who, in his Anatomy of Melancholy, declares there are eighty-eight degrees of it.

Pinel's distinctions in classifying he thinks must be viewed with great caution, as he refines too much. Esquirol he has a better opinion of, though he objects to the substituting of the new and compound word *mono-mania* for melancholia, the latter word being sufficiently expressive, besides being universally received and understood; this notwithstanding his previous restrictions as to its significance. "This phrase," he says, "appropriately enough expresses that variety of melancholia not infrequently met with, which exhibits a solitary delusion; and to that sense it should be restricted." His chief objection, however, to the word monomania, is that it has been adopted by the phrenologists to express the idea that different hallucinations are dependent on the deranged function of that particular organ, or portion of the encephalon which exercises it. The latter objection has hardly been urged, I imagine, during the present generation.

Burrows finally offers an arrangement of his own, simply as a basis for discussion, prefacing it with the advice to divest the mind of all predilections for systems, definitions and nice distinctions in attempting to arrange a system for one's self. His order is as follows:

1. Delirium—Delirium Tremens.
2. Mania—Puerperal Insanity.
3. Melancholia—Suicide.
4. Hypochondriasis.
5. Demency.
6. Idiocy.

This plan is very similar to Esquirol's of *mania, monomania, demency* and *idiocy;* monomania being changed into melancholia, and hypochondriasis added.

Prichard, who wrote a very excellent book in 1837, entitled "A Treatise on Insanity and other Diseases affecting the Mind," followed in the wake of Pinel and Esquirol, and strongly advocated moral and intellectual insanity as two forms of mental disease. Insanity he called a chronic disease, chronic apparently being used in the sense of continuous. This disease he regarded

as manifested by deviations from the natural and healthy state of the mind, such deviations consisting either in a *moral perversion* or a disorder of the feelings, affections, and habits of the individual, or in *intellectual derangement*, which last is sometimes partial, namely in *monomania* affecting the understanding only in particular trains of thought; or general and accompanied with excitement, namely, in *mania*, or *raving madness;* or, lastly, confounding, or destroying the connection, or association of ideas, and producing a state of incoherence.

Prichard was much impressed with the completeness of the arrangement of Heinroth, which for the time was very elaborate. Heinroth made three classes of mental diseases, corresponding to the three departments of the mind. The first class consisted of disorders of passion, feeling or affection of the moral disposition. The second, of disorders affecting the understanding, or the intellectual faculties. The third, of disorders of the voluntary powers, or of the propensities and will. These classes were subdivided into two forms, the first one being exaltation, the second depression; and still further subdivisions were made.

The systems of classification of Haslam, Burrows and Prichard, which I have detailed above, do not call for special comment from a critical point of view at the present day, as time has clearly enough pointed out these defects, and they carried their moral with them. They are, however, of great interest in their bearing on the advancement made in the knowledge of insanity. The most prominent features, or characteristics of mental disease, namely, excitement, or depression, mania or melancholia, had been recognized long before the time of Haslam. They were always present in all cases of insanity, and it was then, and is now for that matter, almost impossible to speak of mental diseases without referring to these conditions. Beyond these terms the early writers had too little knowledge of even the external manifestations of disease, to arrange a classification, and it has been better for succeeding generations that they did not indulge in speculations, which would have been founded on ignorance, and would have rendered the whole subject even more vague and confused than it was at the beginning of the century.

Conjointly with the advent of Pinel and Esquirol, speculative psychology was assuming a more practicable and tangible form. The qualities of mind, the elements of ideation, and mental processes in general, were interpreted in a more rational manner. This progress in the knowledge of normal mental phenomena

happened at a most fortunate time, coming as it did, when the accurate and fresh observations of these masters of practical research just mentioned, called for a more full and scientific system of arrangement than had as yet been possible. They availed themselves of the opportunity offered, and though they were not able to arrange a system, in either case, which could be satisfactory for all time, they did throw some light on important principles, and pointed out the way for further work in the same direction. Perhaps the greatest service Pinel and Esquirol did to the medical profession, was to elevate the specialty of psychiatry to a position both scientific and dignified, which it had previously held to a less degree.

The works of Burrows and Prichard reveal to us the amount of knowledge possessed by the English on the subject of general paralysis of the insane in the early period of its discovery, and what they write is of interest as bearing on classification, though I can only say a word here in reference to it.

Burrows treats of paralysis as a complication of insanity. He has taken most of what he says from Esquirol and Georget, especially the latter, but has modified their views somewhat in accordance with his own, and nowhere describes a true paralysis of the insane, though the description of chronic-muscular paralysis, taken probably from Georget, corresponds in many ways to it.

He thinks very few persons die of paralysis in England, and cannot understand why half of the insane inmates in French asylums, according to Esquirol and Georget, should die of this disease.

Prichard, writing in 1837, or about ten years after Burrows, takes a much wider and more scientific view of general paralysis of the insane than the latter, though the observations of Calmeil were published already as early as 1826. He describes the three stages of the disease, taking his descriptions chiefly from the French writers, and quotes enough from these writers to show how little we have advanced on them in the descriptions we are able to give of general paralysis, as far as the essential features of the disease are concerned.

It is surprising to find that Esquirol had as many as one hundred and nine paralytics under his charge during three years at Charenton. Of these, ninety-five were males, which would leave fourteen cases among females, or rather more than twelve per cent, which is a considerably larger proportion than I should have looked for, so many years ago.

Both Esquirol and Prichard did not agree with Burrows that general paralysis of the insane was a comparatively rare disease in English asylums. They were inclined to regard this conclusion as due to deficient observation, rather than to the rarity of the disease. We can readily believe that such was the case, as in later times the number of cases under similar conditions of imperfect and unskilled observation, was underestimated in this country. Now the proportion of these cases, especially among females, seems to have rapidly increased, but we cannot doubt that this increase is partly accounted for by more accurate observations. And partly perhaps it is a matter of fashion, the diagnosis being often made on insufficient, not to say scanty evidence.

General paralysis of the insane was first admitted into a classification of insanity, so far as the writer's knowledge goes, not over thirty years ago, though as said above it was recognized many years before, first by Bayle in its connection with insanity, though most accurately and carefully described by Calmeil.

To me, even at the present day, it is a matter of doubt whether general paralysis of the insane should be found among the forms of insanity in the most restricted sense. And some day I believe we shall take it away from these forms, and place it, from its closer pathological connection, among the paralyses. But this will be at a time when classifications can be made on strictly scientific grounds, and not as now, on practical grounds, which afford the only secure footing for our present needs.

Since the time of Prichard, new systems of classification have been constantly made. I can allude here to only the most important of these, though all are of interest in one way and another.

About the time of Prichard (1836) Jacobi, representing the somatic school of German psychology, brought forward the theory of the physical basis of mental disease, and though his idea that insanity existed solely as the consequence of disease in some part of the body,* was a little stretched, the general principle involved in his theory, showed a great advance over the former purely psychological theory.

Thirty years ago the study of classification received a fresh impetus from the researches of Schroeder Van der Kolk, Morel, and Skae. The first of these considered the subject from a somato-ætiological point of view, or as Tuke calls it, "a pathogenetic standpoint." He made the two kinds of *idiopathic* and *sympathetic* insanity. Instances of the first were acute and chronic idiopathic

* Bucknill and Tuke—Treatise on Insanity.

mania, hallucinations, &c. Of the second, sympathetic mania, melancholia proceeding from the colon, &c. The plan of this system, which attempts to trace the nature and origin of disease, is most admirable. The only trouble with it is, that it assumes that we know these data, which even to-day we do *not*. This being the case it is useless, a classification being necessarily, an arrangement of previously ascertained data.

Morel's plan (1860) like most of those emanating from the French school of psychology was reasonable in most of its details though extended to take in idiopathic insanity (Group IV,) and sympathetic insanity (Group V.) His conception of *idiopathic* is quite unlike that of Schroeder Van der Kolk, taking in progressive weakening or abolition of the intellectual faculties, resulting from chronic disease of the brain or its membranes. General paralysis is also included in this group, and this is the earliest instance of its appearance in a classification, that the writer remembers. There may have been some earlier mention. Group I, or hereditary insanity; Group II, or toxic insanity; Group III, or insanity produced by the transformation of other diseases, and Group IV, or dementia, "a terminative state," are all good in the light of more recent years, as far as these headings are concerned. It is only in their details, which I cannot go into here, that they are crude, or unscientific.

The ætiological system of Skae, contained much food for thought, being well worked out, and in many ways very suggestive. If there were any hope that such a system could be made to include all varieties of insanity, its adoption might be seriously considered, but with its thirty-four forms, it falls so far short of giving all the causes of insanity, that it would constantly be found to be imperfect. On the other hand as it is, it introduces a large number of heterogeneous forms, and necessarily so, many of which an ordinary observer would never meet with, and consequently would always find a burden and never a help.

At the International Congress, in Paris, in 1867, an attempt was made somewhat similar, I should judge, to that of the Antwerp Congress, to adopt a system which is excellent in some directions, but very disappointing in others. Form I, called *simple insanity*, includes mania, melancholia, monomania, circular insanity and mixed insanity, delusion of persecution, moral insanity and the dementia following these different forms of insanity. From this list, form I, would seem to include almost all kinds of insanity, and it practically does, with the exception of forms II, epileptic

insanity, and III, paralytic insanity, or general paralysis of the insane. The report very truly says that "this form of disease is a morbid entity," and so it is, but whether it is "not at all a complication or termination of insanity," depends very much upon its ultimate correct classification. *Senile dementia* is put by itself in form IV, and form V is *organic dementia*, which is the sequence of no form of insanity, but "is consequent upon organic lesion of the brain, nearly always local, and which presents, as an almost constant symptom, hemiplegic occurrences, more or less prolonged." I fail to see the necessity which calls for the last form, neither can I see why, strictly speaking, such dementia should be classed under insanity at all, unless it be made one form in a general class, including all dementiæ. It is refining beyond a point in harmony with the system in other particulars.

Forms VI and VII were respectively *idiocy* and *cretinism*. Outside of the above so-called "typical forms," others were made such as: delirium tremens, delirium of acute disease, simple epilepsy.

The above system was neither theoretically nor practically successful, and a committee appointed by the British Medico-Psychological Association in 1869, recommended another system, based upon those of Dr. Skae and the International Congress.

The most striking mistake of this system was to make two great classes of curable and incurable forms, not only because these words are undesirable in themselves, as giving a hopeless prognosis in the incurable forms, but equally because the word curable is indefinite and, in a large percentage of cases, not true to the facts. Neither of these words can be used with propriety, or safety, in the classification of mental diseases.

The first five of the curable forms of the British Committee, or the first ten, if we use the sub-divisions of mania and melancholia, are forms occurring only in women. They are the insanities of pregnancy, child-birth, lactation, climacteric insanity, and insanity from uterine disorder. The last curable form, hysterical insanity, should come next as occurring almost entirely among women. The other curable forms include the insanities from tuberculosis, masturbation, alcoholism, delirium tremens and post-febrile insanity. It is incredible why delirium tremens should be inserted among these forms, as it is the only form of delirium given, and is certainly no proper form of insanity under any circumstances.

The arrangement of the incurable form is very puzzling, and I must confess it is to me quite inexplicable. It is as follows: 1, General Paralysis. Paralytic Insanity. 2, Epileptic Insanity.

Epileptic. 3, Senile Insanity. Senile Dementia. 4, Paralytic Insanity. Organic Dementia. It will be seen that there is no place in this arrangement for ordinary terminal, or secondary dementia, as Spitzka has already pointed out.

I have ventured to give the system reported to, but not accepted by the British Medico-Psychological Association, because it represents an effort of twenty years ago to produce a standard of classification in keeping with the times, and under the most favorable circumstances, yet, although there are striking merits in its arrangement, it practically fails, and fails because it does not find the correct principle to make it easily appreciated, and simply applied. This system serves also the further purpose of making a contract with the recent advances in this subject, as I shall show further on.

During the last twenty years, in Europe, and the last ten in America, remarkable progress has been made in the direction of a better understanding of psychological medicine as a science, and it is during these years that the volume of written communications has vastly increased. Many of our most able observers have published treatises, or monographs, in which classifications of insanity have been presented. Among these may be mentioned Griesinger, (though chronologically a little earlier), Maudsley, D. Hack Tuke, Tuke Batty, Bucknill and August Voison, as belonging to the first half of the twenty years. Among those of the latter period are Krafft-Ebing, Westphal, Schüle, Meynert, Clouston, Savage and Spitzka.

The systems of all these writers contain many points of value, those of Krafft-Ebing and Clouston being especially valuable. No two are alike however, and some of them are much too confused and elaborate for every-day use.

Krafft-Ebing makes the mistake, of the British Medico-Psychological Association, of separating curable from incurable forms, which cannot be other than unfortunate. His general plan of making two groups, the first of which includes "mental affections of the developed brain," and the second, "mental results of arrested brain development," is accurate, and therefore good. Division II, of "psychical degenerative states," from our American standpoint, is too elaborate. Division III, "brain diseases with predominating mental symptoms," includes dementia paralytica, *lues cerebralis*, chronic alcoholism, senile dementia, acute delirium. The mistake here made is in the nomenclature, for brain diseases are not necessarily cases of insanity, and in the above heading

the central fact of the existence of insanity does not stand out with sufficient prominence.

The chief merit of Krafft-Ebing's system is, that it is essentially a clinical one, and takes its nomenclature from the most conspicuous features of each form, of whatever nature. It is in this way accurate and reliable.

Whether we wish to adopt the form of *Verrücktheit, primäre* and *secundäre* is still an open question. In the writer's opinion we are passing through a dangerous period of word-coinage, and though the temptation is strong to rehabilitate our ideas in neat, tailor-made phrases, it is better to err in the direction of too few, rather than too many of these expressions. Dr. Clouston, as you are well aware, has recently suggested an ingenious system of nomenclature, which like most of his work, is both original and meritorious. He has a skillful way of catching the most salient point in any matter under discussion, and transfixing it in black and white, with almost photographic accuracy. Even in his classification he has shown this same talent, and evolved a system which gives a correct view of the scientific theories of mental diseases and allied conditions, and his new names, like specially constructed tools for an unusual purpose, are very convenient, even "handy," I was about to say—whether they are correct, will bear the test of time, and can be adopted without hesitation, are questions into which I need not enter into detail here. I can only say that I think the time has not arrived yet.

The International Congress of Psychiatry and Neurology, held at Antwerp in 1885, inaugurated a new movement in the consideration of the classification of mental diseases. The starting point of this movement was a report of Professor Lefebvre on "The Best Basis of International Statistics Regarding the Insane," presented to the Congress on behalf of the Societé de Medecin Mentale of Belgium, which appreciated the need of greater uniformity in classsification, if any results were to be accomplished in the compilation of statistics.

Professor Lefebvre's paper was admirable in tone. He recognizes the fact that we are still in the chaotic period of classification. It is impossible in the present state of science to exactly define all types of mental disease, but a certain number of morbid types can be selected, under which sub-divisions can be arranged from time to time. If the best authorities are examined it will be found that seven or eight types are generally accepted, and from a clinical point of view, these types are necessarily thus limited.

The Professor's own system is as follows: *Idiocy, cretinism; paralytic insanity; dementia; insanity produced by intoxication; mania; melancholia; folie circulaire.* Few authors, he thinks, would be disturbed by this classification. These eight types fall into two groups. The five first could be grouped under the title *organic insanity*, and the three remaining types, which are characterized by nervous and intellectual disturbances of obscure origin, could be called the *neuro-psychoses.*

"If," Professor Lefebvre says, "we seek faithfully to obtain widespread and statistical information, covering the eight types we desire to see adopted, valuable material would be afforded for the study of psychiatry, and the allied sciences. But in confining the matter to the eight principal types of mental diseases most widespread, we should not forget the many forms of mental diseases that clinical observation reveals to us, but see that they are mentioned in some manner, and where related under the organic forms. This is our idea in the matter: the statistics of insanity should be condensed in one grand total concerning idiots, the demented, maniacs, &c., which should show their sub-divisions, and the various forms of idiocy, dementia and mania; but this grand total should comprise every form and variety of the disease."

The essential feature of Professor Lefebvre's system would appear its adaptability for statistical purposes chiefly in asylums, and this fact should be borne in mind in any consideration or criticism of systems growing out of the Antwerp Congress.

Professor Meynert, in a paper published last year, correctly says of the above system of Professor Lefebvre that dementia should be considered as a secondary stage of other forms—altogether Meynert thought this classification too limited. Neither did he agree to the additions of Semal and Magnan of hereditary mental disorders and chronic delirium. Intermittent mental disorder, he thought from its richness of forms, should be taken up.

Meynert alludes to the excellent system of Westphal, published in 1885, which included—1, *Melancholia;* 2, *mania;* 3, *secondary mental disorder;* 4, *paralytical mental disorder;* 5, *mental disorder and epilepsy;* 6, *imbecility, idiocy and cretinism;* 7, *delirium tremens.* He seems to think well of it, and speaks of the efforts of Westphal, to amplify and not curtail a system, as illustrative of the fundamental German plan.

Meynert well says that "every classification is good which comprises within itself all possible learning of its day, and none

should stand which goes beyond that." This is extremely true as an aphorism, but when the test of ordinary knowledge and use is applied to it, the aspect of the case is changed. Is a classification to be used by the comparatively few on the pinnacle of learning, or by the many less well-informed who desire a simple system for practical purposes? Perhaps Meynert would say that ignorance should be no excuse, but the most scientific being the best, should be held up as the only one. Such a plan, I fear, would not work in practice.

Meynert's own system is an illustration of a classification which comprises within itself much of the learning of the present day, more especially in Germany, but can we accept it as the basis of an international arrangement? It looks simple enough on the face of it, yet I fear not one out of ten, and perhaps many more, would clearly understand it. It is to me personally very fascinating, though I must confess I had to carefully study the accompanying explanations, before I mastered it. It is both scientific and philosophical, and even inspiring when viewed from Meynert's own standpoint, and especially interesting because of a certain kind of suggestiveness it contains, naturally leading to a broader view of insanity. An example of the correctness of this statement in the last division, called "Individuals who need watching—(attempts at suicide, crimes, &c.,)" Meynert says that "individuals who need watching are not diagnosable as insane. Attempts at suicide and crimes which are explainable as the result of insane ideas, fear, alcoholism, are not the crimes of individuals who need watching. Still the latter, on account of the interest that is to-day taken in crimes in their aspect of abnormal psychical phenomena, should be statistically classified in asylum reports."

Now this is broad, scientific humanitarianism as applied to mental diseases, and especially worthy of consideration, because of the narrow and prejudiced views of lawyers and jurists. But can we practically make use of this classification in our American asylums in compiling our statistics? That is the question that confronts us. Our asylums in this country are for the insane alone, with few exceptions. In isolated instances, in certain states, doubtful cases are sometimes sent to the asylum for observation. These persons have committed crimes, and their insanity is a matter of doubt. Few even of this class, however, reach the general asylum, the period of doubt being passed in a jail or prison. The asylum receives, and in my opinion should receive,

only undoubted cases of insanity. The moment that the asylum admits the sane with the insane, the legal and moral status of the institution must be modified, and the result is unfavorable to the best interests of the insane. Therefore, in my opinion, "individuals who need watching," should be placed in a special department of a criminal lunatic asylum, or some other specially prepared department to remain until proved sane or insane. Under these circumstances, it will be seen, that we can practically make no use of the above suggestive form of classifications.

Other objections to Meynert's system readily occur, which render it unfit for practical use in our American asylums. These objections arise largely from our own scientific backwardness, but they are, none the less, insurmountable for the present.

At the Antwerp Congress, an "International Committee on International Statistics of the Insane and Classification of Mental Diseases" was organized, Clark Bell, Esq., president of the New York Medico-Legal Society, being the member for America. Through the efforts of this committee, considerable good work has been done since. Systems of classification containing many admirable features have been prepared by Professor Verga of Italy, Guttstadt of Germany, Benedikt of Austria, Wille of Switzerland, Mierzejewski of Russia, Steenburg of Scandinavia, Dr. Hack Tuke of England, Magnan of France, Raemer of Holland. Within a recent period in this country classifications have been published by Drs. Edward Cowles, R. H. Stearns, and H. M. Bannister. These various systems cannot be discussed here for lack of necessary time. But it cannot be doubted that they will each contribute something of value toward the general result of a practical, and therefore acceptable system of classification.

In September last, at the invitation of Mr. Bell, the American member of the international committee, a conference of alienists was held to prepare an American classification, which Mr. Bell could present in his report to the general committee.

At the conference, Dr. Pliny Earl, formerly president of the American Association of Asylum Superintendents, represented the Medico-Legal Society of New York, and also presided over the meetings. Dr. R. H. Stearns appeared as the delegate of the association just mentioned, and Dr. J. P. Bancroft and the writer appeared as representatives of the New England Psychological Society. Drs. Ira W. Russell and W. B. Fletcher were also present.

The conference considered various systems of classification, and considered them only in the light of an arrangement for the compiling of asylum statistics. For this purpose no one was satisfactory, though the English system most nearly approximated to what was wanted.

The gentlemen present will remember that this system, recently accepted by the Council of the British Medico-Psychological Association, and published in the *Journal of Mental Science* for July, 1886, is as follows:

I. Congenital, or infantile mental deficiency. Idiocy. Imbecility. Cretinism. *a*, With epilepsy; *b*, Without epilepsy.

II. Epilepsy acquired.

III. General Paralysis of the Insane.

IV. Mania, ...
- Acute.
- Chronic.
- Recurrent.
- A potu.
- Puerperal.
- Senile.

V. Melancholia,
- Acute.
- Chronic
- Recurrent.
- Puerperal.
- Senile.

VI. Dementia, ..
- Primay.
- Secondary.
- Senile.
- Organic, *i.e.* from tumors, hæmorrhage, &c.

VII. Delusional Insanity (monomania.)

VIII. Moral Insanity.

Dr. D. Hack Tuke thought that recurrent insanity should be left out, because it usually required one year of observation before it could be certainly diagnosed. He also submitted on his own behalf several sub-divisions.

The plan of classification finally adopted by our American conference, and presented for discussion to-day, is as follows:

1. Mania,.....
- Acute.
- Chronic.
- Recurrent.
- Puerperal.

2. Melancholia, ..
- Acute.
- Chronic.
- Recurrent.
- Puerperal.

3. Primary Delusional Insanity (monomania.)
4. Dementia,..... { Primary. / Secondary. / Senile. / Organic (tumors, hæmorrhages, &c.)
5. General Paralysis of the Insane.
6. Epilepsy.
7. Toxic Insanity—(alcoholism, morphinism, &c.)
8. Congenital Mental Deficiency,.. { Idiocy. / Imbecility. / Cretinism.

The conference considered for some time whether the congenital forms—I here mean idiocy, &c.,—should be placed first or last. In my own opinion they should come first, as such is their natural order, and natural order should be adhered to as far as possible. These forms are, however, already of practically very little importance to us, as the number of idiots is almost nothing in American asylums, and will soon wholly disappear. I trust that I shall not be accused of boasting, if I venture to assert that the United States is in advance of other countries in institution provision for idiots. A recent paper of Dr. W. W. Ireland for instance, on "The Admission of Idiotic and Imbecile Children into Lunatic Asylums,"* shows how far behind us England is in this respect. Dr. Ireland takes very strong ground in this paper on the evils attending these admissions. In one place he says, "Surely this confinement of idiotic children in asylums is an outrage both to the idiotic and the insane." He "knows of idiots of low type who are kept in asylums with lunatics in all the stages of their attacks and recoveries."

A committee, consisting of Drs. Campbell, Clouston, Ireland and Rutherford was recently appointed to ascertain the actual number of idiots in English asylums; this having never been done before. In thirty-one county asylums they found that there were 1,857 idiots, which certainly shows they cannot, in English tables, leave out idiots and imbeciles. As far as our lunatic asylum statistics are concerned, this might be done in the United States, as already intimated, but in our classification we naturally included these classes, in deference to the idea of international unity.

In our system we followed the time-honored custom of putting mania first and melancholia second. It sounds more natural,

* Journal of Mental Science, July, 1886.

having been done so long ago as the time of Haslam, as I have already said. It is, however, not ætiologically correct, and in time states of depression should precede states of exaltation, as being the sequential and therefore the natural and proper order.

I can hardly agree with Dr. Tuke, that recurrent forms should be omitted, because a long time is necessary for their diagnosis. While this is true in some cases, it is not true in others. The history of the patient alone often pointing to the alternating character of the disease. Furthermore, as far as my observation goes, this type is growing more common, or we are becoming more skilled in its detection. It is, at any rate, in my opinion, important to leave a place for alternating forms.

It will be observed that we omitted *mania-a-potu*, I think with benefit. This term is rarely used with us, and under toxic insanity a place can be made for cases arising from alcoholism, either acute or chronic; or where the alcohol has been a less direct cause, producing a form of mania or melancholia, precisely similar to these forms, it will be sufficient to place it with them.

Our Form 3 of "primary delusional insanity" was the only term coined for our arrangement, and is naturally the one most open to criticism. We desired to do away with *monomania*, an expression which has slowly lost its significance, until it is now relegated to brackets, and will soon be lost in oblivion. This form corresponds to *primäre Verrücktheit* of the Germans, a term much affected by those who like new and unusual names, rather than plain and common ones. The meaning of the term is excellent, and we are indebted to the Germans for throwing new light on the condition which it describes, but the introduction of technical terms in a foreign language bodily into our own language is unscientific, and frequently perplexing, and must sooner or later be abolished for an English equivalent.

Paranoia is better than *primäre Verrücktheit*, and would in time become assimilated into the language, but an English expression is still better. We accordingly adopted *primary delusional insanity*. The use of the word "delusional" has been criticised, but as it helps to define the intention of the word, and serves as a connecting link with monomania in the minds of those inclined to cherish this word, it strengthens rather than detracts from, the significance of the expression.

Of Form 4, which includes the dementias, little can be said. It is a duplication of form V of the English system, and adopted in conformity to this system.

Form 5, is general paralysis of the insane, which finds its place here appropriately as an organic form of disease. I have already intimated that this form of disease did not seem to me to belong, in the most restricted sense, to mental diseases, but usage at present classifies it with these diseases and it must enter into any system. The term is much too long and unsatisfactory as the name for a form of mental disease. General paresis is better, but not what is wanted. Paralytic insanity is incorrect, and paretic dementia or paralytic dementia cannot be advocated, though used somewhat by both French and Germans. It is simply making a new form of dementia and confusing it with the general class of secondary forms. These forms of dementia are too numerous now, and we should hesitate to add to them. The chief merit of the expression is its brevity.

Form 6 is epilepsy, more properly epileptic insanity, the name of the primary disease being used in deference to the English system.

Form 7 alone remains to be mentioned, which is "toxic insanity." The value of the expression as the general name of a supposed group almost entirely limited to one form of disease is a question which time will determine. It has the sanction of many authorities.

I have simply called your attention to some of the points which arose in our consideration of the formulating of a new system. Our guiding thought was utility for the purpose intended. The entering wedge toward the adoption of an international system seemed to lie in the acceptance of a plan which would approximate to that of some other country whose ideas were most nearly in harmony with our own. That country was found to be England, hence, in part, the similarity of classification.

If such a thing as an international system is ever possible, which I am somewhat skeptical about, it will be when our scientific advancement has arrived at the same approximate point, and when we can view disease from a practically unanimous point of view. We shall then have no doubt what each other means, and shall employ our time harmoniously in arranging and labeling our morbid phenomena, and not in vaguely interpreting something we are ignorant of.

At the present time we must be satisfied to lay a few foundation stones, or else adopt two systems, one suited to asylum statistic compilation, and the other to the varying scientific needs of the different countries.

No system has attracted me more as a starting point, or foundadation for elaboration than that of Professor Wille of Basle. As you will remember this is as follows:

1. Psychoses Congenital, { Idiocy. / Imbecility.
2. Psychoses Simple.
3. Psychoses Organic,.. { Psychoses Paralytic. / " Senile. / Other organic psychoses.
4. Psychoses Epileppi.
5. Psychoses by intoxication—Alcoholic Psychosis and others.

This arrangement is extremely simple, and yet would allow of indefinite expansion.

One objection that may be urged to it is the use of the term "psychosis." It has already been frequently used to signify mental disease, but never as yet has been formally accepted. I think it highly desirable to use some new term instead of "insanity," "mental disease," "mental disorder," "mental alienation," &c. These words are too long, and either too definitive, or lacking in scientific accuracy. We need a medical term, restricted to the use of physicians, applicable, scientific and short. Such a term will help to further dignify the specialty of psychiatry, and to set it still more remote from the category of moral infirmities as understood by the ignorant. I urged the adoption of the term "psychosis," at our American conference, though at that time we wisely decided against it. It may be that a new term must wait for the approval of time and usage, but if it were possible to more forcibly introduce it, in my opinion no greater service could be done by a medical congress than to substitute such a term as "psychosis" for the above unscientific and objectionable ones.